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DC DOH

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THE DISTRICT OF COLUMBIA

HEALTHY PEOPLE 2010 PLAN

A Strategy for Better Health

Government of the District of Columbia
Anthony A. Williams, Mayor

THE DISTRICT OF COLUMBIA

HEALTHY PEOPLE 2010 PLAN

A Strategy for Better Health

September, 2000

I am pleased to present to you a copy of the District of Columbia HEALTHY PEOPLE 2010 PLAN. This Plan provides strategies for improving the health of residents by the year 2010.

The goals and targets in this Plan have been developed to improve the quality of life for each District resident. This means more than the absence of disease. It means maintaining one's physical and mental health.

We are working to improve the health of District residents by expanding our community health programs and increasing access to health care coverage. However, a healthy city ultimately requires personal responsibility. Our residents must understand that they are responsible for maintaining their health and that everyday choices will influence their well-being.

I am committed to the objectives of this Plan and their realization by the year 2010. Through strong public-private partnerships, we can support community health programs and achieve the goals of Healthy People.

I challenge each citizen and city agency to join me in implementing our HEALTHY PEOPLE 2010 PLAN. Together, we can improve the quality of life for children, youth, families and individuals in the District by making health a high priority.

Anthony A. Williams
Mayor

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I take great pleasure in introducing the Department of Health's District of Columbia HEALTHY PEOPLE 2010 PLAN. The purpose of this Plan is to set broad goals to improve the health of all District residents. The District's plan is part of a national effort to improve the health of all Americans by the year 2010.

The Plan was developed with input from health professionals and community representatives who set targets for health status improvement that can be reached by the year 2010. This Plan was developed in accord with the federal Healthy People 2010 framework and by obtaining input from local citizens and community agencies. Information was also used from the District's Healthy Residents Year 2000 Plan.

This Plan provides a blueprint for improving the health of all residents of the District of Columbia. A major theme of the national and local HEALTHY PEOPLE 2010 PLAN is to reduce the disparities in health status between races.

The Department of Health will continue to form partnerships with public and private agencies that will enable us to realize the goals of the HEALTHY PEOPLE 2010 PLAN. Our goal is to engage each resident in a collaborative effort to improve his or her own health, as well as that of the family, the neighborhood and ultimately the community.

I encourage all residents and representatives of community agencies to join me in the challenge to close the gap in health status that separates residents and communities, so that life in the District will be healthier and more enjoyable for all who reside here.

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Director, Department of Health

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PLANNING PROCESS

The HEALTHY PEOPLE 2010 planning process is a national effort to address the major threats to good health and long life for all Americans. The process sets the disease prevention planning agenda for the nation. It's goal is to encourage state health agencies to develop similar plans within their jurisdictions to improve the health status of the community.

The HEALTHY PEOPLE 2010 PLAN for the nation differs from previous disease prevention and health promotion campaigns announced by the Surgeon General in that it focuses on eliminating health disparities among racial and ethnic minority populations. For the major diseases addressed in the Plan, targets are defined according to specific population subgroups. The Plan recognizes differences in disease outcomes among specific population groups as defined by race and ethnicity, gender, age, socioeconomic status, educational attainment, and other variables. Furthermore, it proposes to close the gap in health status between white Americans and Americans of minority origin by 2010.

The District of Columbia Department of Health (DOH) is responsible for recognizing and serving the health needs of District residents. It sets the agenda for disease prevention and health promotion among local residents, whose needs may or may not coincide with those of people residing in other communities. Even within the city, the health needs of the diverse population subgroups of city residents are similar in some instances and divergent in other instances. Consequently, meeting the health needs of the diverse population subgroups among District residents may require DOH program staff to develop a variety of measurable, culturally sensitive, and cost-effective disease prevention and control activities. The District of Columbia HEALTHY PEOPLE 2010 PLAN presents the proposed strategies for closing the gaps in health status among residents.

The DOH mission is to ensure a safe and healthy environment for city residents. This mission drives its development of the District of Columbia HEALTHY PEOPLE 2010 PLAN, which includes the following focus areas:

1. Asthma;
2. Cancer;
3. Diabetes;
4. Disabilities;
5. Emergency Medical Services;
6. Environmental Health and Food Safety;
7. Health Care Finance;
8. Heart Disease and Stroke;
9. HIV/AIDS;
10. Immunization and Infectious Diseases;
11. Injury/Violence Prevention;
12. Maternal, Infant, and Child Health and Family Planning;
13. Mental Health and Mental Disorders;

14. Nutrition;
15. Pediatric Dental Health;
16. Primary Care;
17. Public Health Infrastructure;
18. Sexually Transmitted Diseases;
19. Substance Abuse;
20. Tobacco; and
21. Tuberculosis.

The District's Plan conforms with the federal Healthy People 2010 Plan development guidelines for improving the health of all Americans. Developed by an interagency work group within the federal Department of Health and Human Services and reviewed in a process of regional and national meetings, the following 10 Leading Health Indicators were selected based on their ability to motivate action, the availability of data to measure their progress and their relevance to broad public health issues:

- Physical activity
- Overweight and obesity
- Tobacco use
- Substance abuse
- Responsible sexual behavior
- Mental health
- Injury and violence
- Environmental quality
- Immunization, and
- Access to health care.

The District will also place a special focus on these 10 areas.

The development of the District's Plan was coordinated by the State Center for Health Statistics. Public comment was actively solicited throughout the planning process; and three public hearings were held.

The planning process includes the following steps:

1. Area Profile and Analysis

- Analyze demographic and socio-economic data;
- Review health status data; and
- Review existing needs.

2. Analysis of Federal Guidelines and State Categorical Health Plans and Existing Policies

- Review federal Healthy People 2010 Plan policies and procedures;
- Review District state plans and policies;
- Establish planning group with work group and program liaisons; and
- Conduct status review of the District of Columbia Healthy Residents 2000 Plan.

3. Citizen Participation

- Establish committees and advisory groups;
- Convene public hearings;
- Receive written comments; and
- Review suggested revisions and sanction certain changes.

4. Plan Implementation

- Develop strategies; and
- Develop an annual implementation plan.

5. Monitor and Evaluate Implementation Activities

- Plan submission to the Director of the Department of Health;
- Plan submission to the Mayor; and
- Plan submission to the U.S. Department of Health and Human Services

The focus areas of this Plan are grouped according to the four federal HEALTHY PEOPLE 2010 PLAN objective areas:

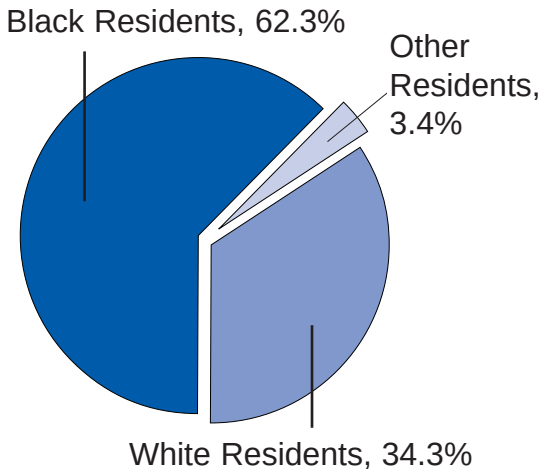
- Promote Healthy Behaviors;
- Promote Healthy and Safe Communities;
- Improve Access to Quality Health Care Service; and
- Prevent and Reduce Diseases and Disorders.

Calendar year 1997 has been chosen as the baseline year for data in this Plan. DOH will produce an Annual Implementation Plan which will be updated each year and contain the latest health statistics for the District.

COMMUNITY PROFILE

As the nation's capital, the District of Columbia is characterized by a distinctive international stature and a diverse population. In its 63 square miles, the District is home to a population which represents many world cultures. The estimated 1998 population of 523,124 is 62.3 percent African American, 34.3 percent white, 3 percent Asian and Pacific Islander, and 0.3 percent American Indian. (Figure 1) Hispanics made up 7.2 percent of the total population. The challenge faced by the District's health system is to address the needs of all its residents, while recognizing the diverse health needs and health status of its numerous subpopulations.

Figure 1: Population by Race, District of Columbia, 1998



Source: DC Department of Health, State Center for Health Statistics, Washington, DC.

In recent years, dramatic changes, in particular the advent of health care management organizations (HMOs), have occurred in the health care arena. These changes have affected the delivery of health care and created new challenges for shaping public health policy. Nevertheless, the purpose for providing health care has not changed. There remains the need to continuously assess

the impact of these changes on public health, on ensuring access to appropriate interventions, on monitoring the overall health system, and on developing appropriate public policy.

In the midst of this changing health care environment, the District of Columbia struggles with a number of health-related problems among its residents. The five leading causes of death in 1998 were heart disease, cancer, cerebrovascular disease, HIV/AIDS, and pneumonia and influenza. Expressed in crude rates, these deaths occurred at rates of 291.1, 258.1, 57.9, 47.0, and 43.8, respectively. Violent crimes, whose victims fill the city's emergency rooms, occurred at a rate of 2,470 per 100,000 population in 1996, almost four times the national rate of 634 per 100,000.The infant mortality rate in 1998 was 12.5 per 1,000 live births compared with 7.2 nationally. Over the past ten years (1989–1998), there has been an overall declining trend in the infant mortality rate (as shown in Table 1 and Figure 2). There were 171 fewer infant deaths in 1998 compared to 1989, representing a decline of 64 percent.

Table 1: Ten-Year Infant Mortality Trends for Residents, District of Columbia, 1989–1998

Year	Births	Infant Deaths	Infant Mortality Rate (per 1,000 live births
1989	11,567	267	23.1
1990	11,806	236	20.0
1991	11,650	235	20.2
1992	10,939	200	18.3
1993	10,614	177	16.7
1994	9,911	180	18.2
1995	8,993	145	16.1
1996	8,377	121	14.4
1997	7,916	104	13.1
1998	7,678	96	12.5

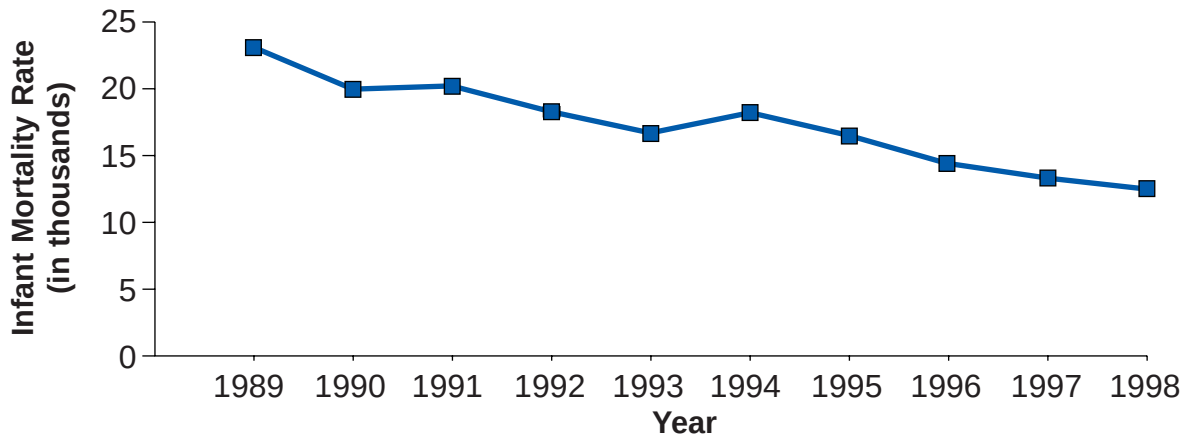
* Only four of five are in large enough numbers to be counted as significant.

Source: DC Department of Health, State Center for Health Statistics, Washington, DC.

An important measure of the health of a population is the number of premature deaths. If 65 is used as the age for deaths due to natural causes in the District, then 36 percent of all deaths in the District in 1998 could be regarded as premature (deaths occurring before the age of 65). The leading causes of premature death were cancer, heart disease, HIV/AIDS, and homicide. Furthermore, to quantify the impact of premature deaths, epidemiologists have employed the measure of “years of potential life lost” (YPLL). This measure aggregates the difference between the actual age at death and the age of natural death for all deaths. For the District of Columbia, the YPLL for 1998 was 66,072 years which translates into a YPLL rate of 14,669.0 per 100,000 population.

Improving the health of District residents depends on identifying risks to health, adopting healthy behaviors and lifestyles, and using health services effectively. To reduce risks to health, the community must be protected from communicable diseases and environmental threats. Furthermore, in-depth analysis of health data indicates

Figure 2: Ten-Year Infant Mortality Trend, District of Columbia, 1989–1998



Source: DC Department of Health, State Center for Health Statistics, Washington, DC.

that health problems occur in disproportionate numbers according to gender, race, and socioeconomic status. For example, in 1998, the death rates from the leading causes of mortality in the District were significantly higher for African Americans than for whites; for heart disease, the rate was 365.5 deaths per 100,000 among African Americans versus 176.5 deaths per 100,000 among whites; for cancer, the rate was 325.0 deaths per 100,000 versus 162 per 100,000, respectively. Thus, the goal of reducing or eliminating health disparities among ethnic groups is particularly important in the District of Columbia.

HEALTH STATUS OF RESIDENTS

The health status of a community is measured by key health status indicators. Together with demographic and socioeconomic data, health status indicators provide a profile of the community and are the foundation for defining the community's health needs and assessing the manner in which the health care system can meet those needs (Table 2). The adequacy of health status measures is predicated on a clear and concise definition of health. It is necessary to know what is to be measured in order to choose the correct tools with which to measure. The World Health Organization (WHO) has defined health as " a state of complete physical, mental and social well-being." A more generally applied concept of health is the absence of illness, disease and disability which leads to the use of health status measures that indicate the occurrence of illness, disease and disability. Health status measures are derived, in many cases, from indicators of ill-health.

Even though measurements of illness, disease and disability are more accessible than measurements of well-being, problems exist with the availability, validity and reliability of data. Inconsistencies are common in the reporting and recording of illness and disease. Only those diseases are reported that the law requires be reported.

The description given in the 2010 Plan of the health status of District residents is a composite of the available quantifiable measure of life expectancy, natality, mortality and morbidity. Other measures include disability, subjective self-reported assessments of health, selected indices of lifestyle, and environmental influences. It is important to emphasize the

Table 2: Health Status Indicators, District of Columbia, 1998

Indicators	Statistics
1. Population estimate	523,124
2. Population 65 year and over	72,710
3. Live Births	7,678
4. Live Birth Rate per 1,000 population	14.7
5. Low Weight Live Births	1,017
6. Births to Teenage Mothers	1,172
7. Births to Unmarried Women	4,829
8. Marriage Rate per 1,000 population	5.5
9. Divorce Rate per 1,000 population	2.5
10. Total Deaths	5,998
11. Crude Death Rate per 100,000 population	1,146
12. Infant Deaths	96
13. Infant Mortality Rate per 100,000 population	12.5
14. Heart Disease Death Rate per 100,000 population	291.1
15. Cancer Death Rate per 100,000 population	258.1
16. Cerebrovascular Disease Death Rate per 100,000 population	57.9
17. HIV/AIDS Death Rate per 100,000 population	47
18. Pneumonia and Influenza Death Rate per 100,000 population	43.8

Source: DC Department of Health, State Center for Health Statistics, Washington, DC.

cultural and ethnic diversity of residents of the District of Columbia. Residents represent many ethnic and racial groups that extend beyond the black and white classifications, characteristic of many data presentations. Data on the Hispanic population is particularly difficult to obtain, because of the lack of Hispanic identifiers on data collection forms, inappropriate interpretation when Hispanic identifiers are used, and the variety of Spanish-speaking countries of origin of Hispanic residents. In this chapter, data identified with the Hispanic population will be used whenever available when describing the health needs of all District residents.

The following narrative describes Life Expectancy, Natality, and Mortality data for the District.

I. Life Expectancy

As a health status indicator, life expectancy at birth is a comparative measure of longevity. Subjecting the reported number of births in a given time period to age-specific mortality rates derives life expectancy. In 1997, the average life expectancy at birth for the United States was 76.5 years (Table 3), which represents a record high.

There are marked differences in life expectancy at birth by race and gender for the total population of the U.S., with females tending to live longer than males and white persons living longer than blacks. For the U.S. as a whole, life expectancy for whites in 1997 was 77.2 years or 6.1 years longer than for the black population. Life expectancy at birth for females was 79.4 years or 5.8 years longer than for males.

Table 3: Life Expectancy at Birth by Race, United States, 1997

Race	Years
All Races	*76.5*
Black	71.1
White	77.2

Source: National Center for Health Statistics, National Vital Statistics Reports, *United States Life Tables, 1997.*

Between 1993 and 1997, life expectancy for black males in the United States increased 2.6 years to 67.2 years. Between 1993 and 1997, life expectancy for black females in the United States increased one year to 74.7 years.

Between 1993 and 1997, life expectancy increased for the white population. Life expectancy for white males increased 1.2 years to 74.3 years in 1997. During the same period, life expectancy for white females increased 0.4 years to 79.9 years.

The difference in life expectancy between white males and black males in the United States was 7.1 years in 1997, while the difference in life expectancy between white females and black females decreased to 5.2 years according to the National Center for Health Statistics. Overall, the largest gains in life expectancy between 1980 and

1997 were for white males (3.6 years), followed by black males (3.4 years), black females (2.2 years), and white females (1.8 years).

Data on the life expectancy of residents of the District of Columbia for 1998 has not yet been released by the United States National Center for Health Statistics.

II. Natality

Natality data for the District are described in two categories: Births and birth rates and fertility rates.

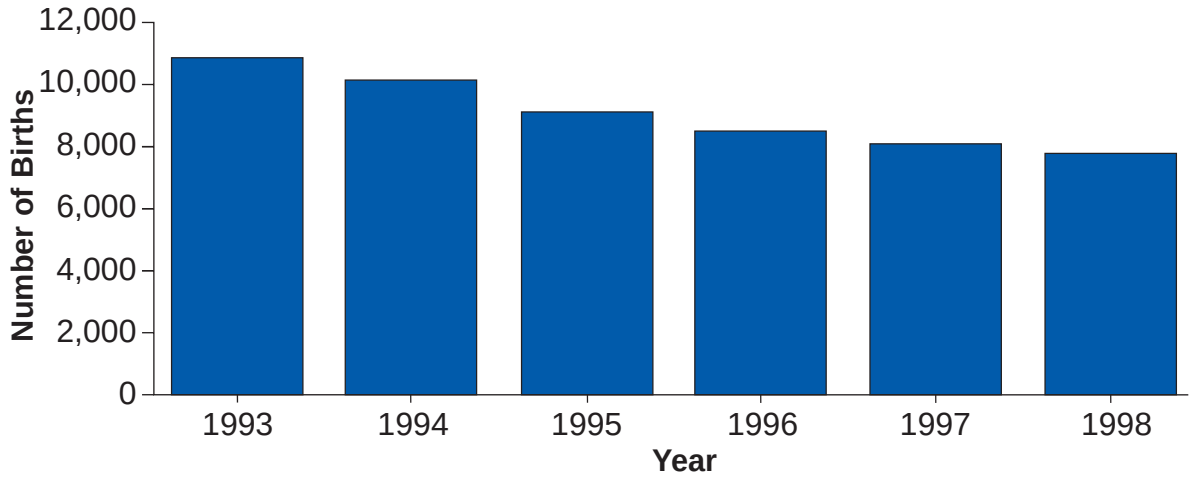
A. Births and Birth Rates

During the 1980s in the District of Columbia, there was an increase in the number of live births and the birth rates, after decreases in the 1970s. By 1990, the number of resident live births was 11,806, 27.5 percent more than the 9,257 live births recorded in 1980. In 1990, the birth rate was 19.5 live births per 1,000 population, up from 14.5 live births per 1,000 in 1980. By 1998, however, the birth rate decreased to 14.7. A similar decline occurred around the nation (NCHS).

In 1998, births to residents of the District of Columbia totaled 7,678 (Figure 3). This figure represents a 33.6 percent decrease over births in 1989 and a three percent decrease over 1997 (SCHS). While the number of live births increased steadily from 1980 to 1990, a slight declining trend was noted from 1991 through 1998, with 3972 fewer births in 1998 than in 1991, a 34.1 percent reduction (SCHS).

In 1980, in the United States, there were 307,163 births to Hispanic women. By 1992, that number had more than doubled to 643, 271 (NCHS). The comparable numbers for the District of Columbia were not available for those early years, since the District was not collecting data on Hispanic births. In mid-year 1989, however, the District began collecting data on Hispanic births; there were 809 Hispanic

Figure 3: Number of Births, 1993–1998, District of Columbia



Source: DC Department of Health, State Center for Health Statistics, Washington, DC.

births. In 1990 there were 941 births to Hispanic women; in 1992, 920. In 1994, there were 886 ,and in 1995, there were 715, representing a decline evident over the past six years. Between 1996 and 1998, the number of births to Hispanic women fluctuated from 853 in 1996 to 646 in 1997 to 762 in 1998.

Births to black women who were District residents numbered 8,510 in 1992; 8,159 in 1993; 7,629 in 1994; 6,681 in 1995; 6,048 in 1996; 5,676 in 1997; and 5,337 in 1998. It appears that there has been a declining trend since 1993.

A declining trend could also be noted in births to white women who were District residents. Births totaled 1,442 in 1992; 1,478 in 1993; 1,354 in 1994; 1,422 in 1995; 1,309 in 1996; and 1,300 in 1997. The number of births increased slightly to 1,304 in 1998. Births in the racial category "Other" were fewer than one thousand between 1992 and 1998, except for 1996.

In 1990, births to women under 20 years of age (teens) numbered 2,102 representing 17.8 percent of all births. In 1991, there were 2,008 teen births or 17.5 percent of all births. In 1992, there were 1,722 or 16.2 percent; in 1993, the figure was 1,823 or 17.2 percent of all births; in 1994, there were 1,550 births to teens (15.6 percent); and in 1995, there were 1,392 births or 15.5 percent. By 1998, the number of births to women under 20 years of age was 1,172 or 15.3 percent (Table 4).

Births among black teenagers decreased 9 percent, from 15.6 percent of total live births in 1993 to 14.2 percent in 1994 and 13.5 percent in 1998. Births among white teenagers decreased from 0.4 percent of total live births in 1993 to 0.3 percent in 1994 and 0.2 in 1995 and increased to 0.4 percent in 1998. Single mothers accounted for approximately two-thirds of all births in the District, decreasing from 73 percent in 1993 to 62.9 percent in 1998.

Table 4: Births to Women Under Age 20, District of Columbia, 1990–1998

Year	Number of Births	Percent
1990	2,102	17.8
1991	2,008	17.5
1992	1,772	16.2
1993	1,823	17.2
1994	1,550	15.6
1995	1,392	15.5
1996	1,406	16.8
1997	1,233	15.6
1998	1,172	15.3

Source: DC Department of Health, State Center for Health Statistics, Washington, DC.

B. Fertility Rates

Another indicator of change in childbearing trends is the fertility rate. The fertility rate is calculated as the number of live births per 1,000 childbearing women aged 15–44. Changes in age-specific birth rates and the number of females of childbearing

age within an age-specific population have an effect on the projected number of live births during a given time period.

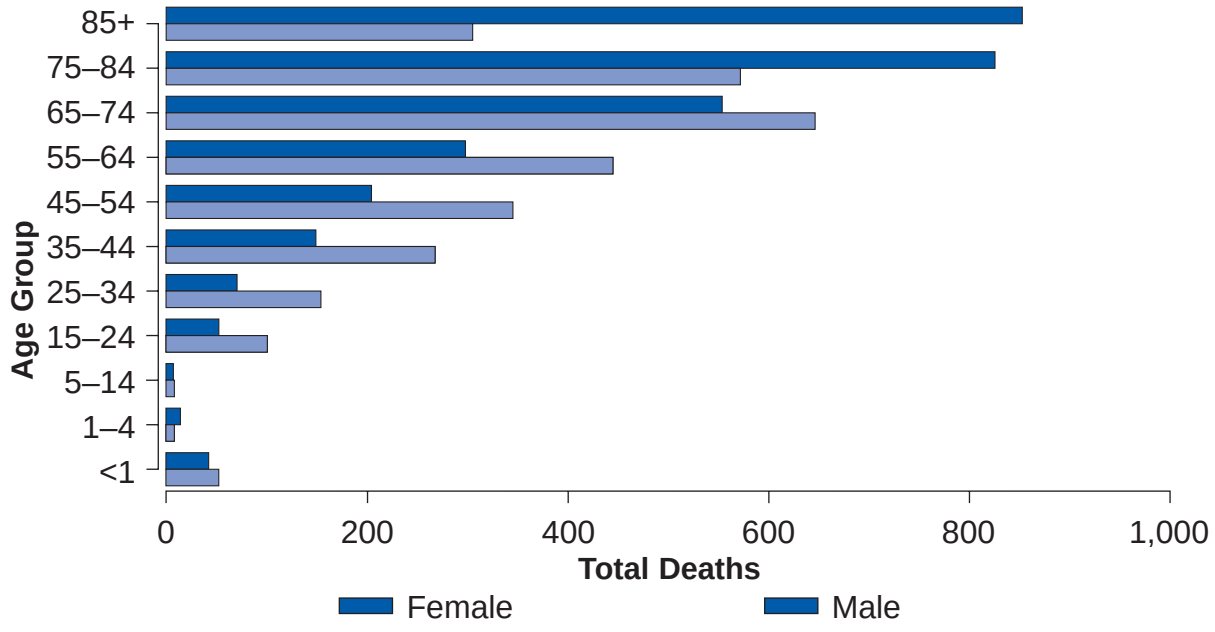
For the U.S. as a whole, the fertility rate declined from 68.4 in 1980 to 65.4 in 1986. After 1986, the rate climbed slightly to 70.9 in 1990. National U.S. data from 1994, 1995, 1996, 1997 and 1998 reflect rates of 66.7, 65.6, 65.0, and 65.6, respectively (NCHS). The District's fertility rate decreased from 68.4 in 1994 to 60.7 in 1998 (SCHS). The District's population of childbearing women ages 15 to 44 was estimated to be 126,427 in 1998.

III. Mortality

This section presents information on various aspects of mortality from the District of Columbia Vital Records system. Figures are presented on the total number of deaths, leading causes of death and infant mortality. It shows trends over time and breakdowns by age, gender, race, and ethnicity.

In 1998, there were 5,998 deaths to residents of the District of Columbia (Figure 4). This represents a crude death rate of 1,146.6 per 100,000 population and an age-adjusted rate of 753.0 per 100,000 population. The District's crude death rate is higher than the national rate, but declining since 1994. The 1998 crude rate for males (1,218.9 per 100,000) was considerably higher than for females (1,082.8 per 100,000) (Table 5). The 1998 rate for blacks (1,442.7 per 100,000 population) was significantly higher than for whites (688.8 per 100,000).

Figure 4: Total Deaths by Age and Gender, District of Columbia, 1998



Source: DC Department of Health, State Center for Health Statistics, Washington, DC.

Table 5: Five Leading Causes of Death by Gender, District of Columbia Residents, 1998

Cause of Death	Total		Male		Female	
	Number	Rate	Number	Rate	Number	Rate
All Causes	*5,998*	*1,146.6*	*2,987*	*1,218.9*	*3,011*	*1,082.8*
1. Heart Disease	1,523	291.1	721	294.2	802	288.4
2. Cancer	1,350	258.1	660	269.3	690	248.1
3. Cerebrovascular Disease	303	57.9	106	43.3	197	70.8
4. HIV/AIDS	246	47.0	172	70.2	74	26.6
5.Pneumonia and Influenza	229	43.8	101	41.2	128	46.0

Source: DC Department of Health, State Center for Health Statistics, Washington, DC.

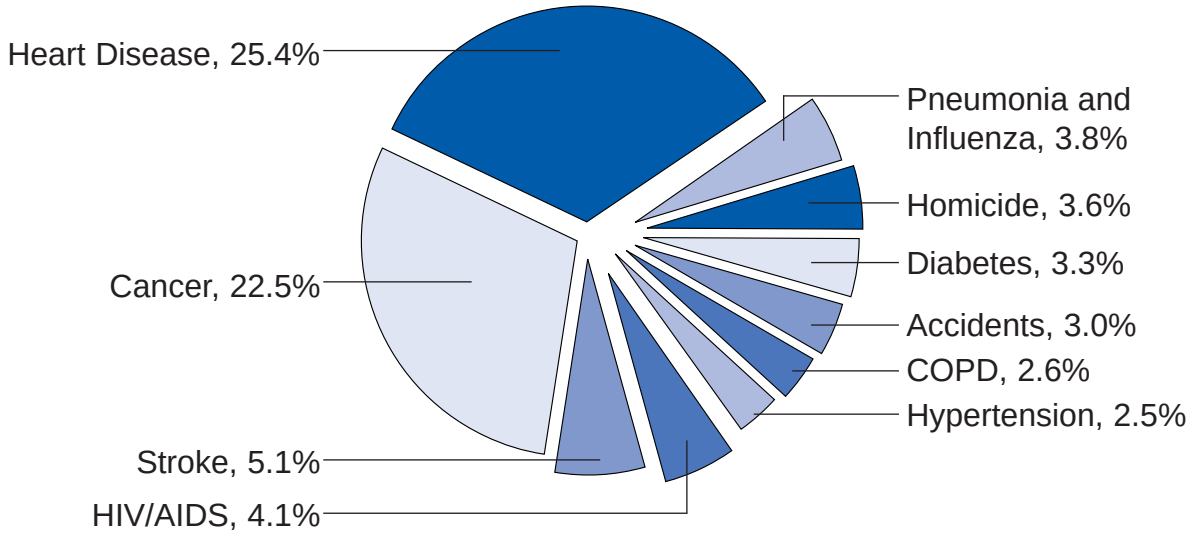
A. Leading Causes of Death

The leading cause of death to the District of Columbia residents in 1998 continued to be heart disease, which accounted for 1,523 or 25.4 percent of all deaths (Figure 5). Cancer remained the second most frequent cause of death to residents, being responsible for 22.5 percent of all deaths in 1998. The third leading cause of death, cerebrovascular disease (stroke), accounted for 5 percent of the total deaths. Together, these three causes accounted for 1 of every 2 deaths in 1998 (53 percent). Deaths due to HIV/AIDS ranked fourth in 1998, with 246 (4.1 percent) resident deaths reported. HIV/AIDS was the third leading cause of death from 1992 through 1996, but declined to fourth place in 1997 and 1998. Deaths due to pneumonia and influenza (3.8 percent) were the fifth leading cause of death in 1998.

1. Heart Disease

Heart disease is the leading cause of death in the District of Columbia as it is nationally and a major cause of illness and disability in middle and later life. From 1994 through 1998, there were 7,871 heart disease deaths in the District of Columbia of which 3,824 were males and 4,047 were females. Some variations in heart disease deaths exist among the city wards in the District. Death rates from heart disease have been highest in Wards 4 and 5 and lowest in Ward 8, consistently from 1994 through 1998.

Figure 5: Leading Cause of Death, District of Columbia, 1998



Source: DC Department of Health, State Center for Health Statistics, Washington, DC.

Although more females than males died of heart disease from 1994 through 1998, male heart disease deaths were on the average twice the number of female heart disease deaths prior to age 65. The greater number of female heart disease deaths for the 65 years and older age group is consistent with the higher life expectancy rate of females.

Heart disease deaths viewed by race showed that a disproportionate number of deaths occurred among blacks (75 percent) in comparison to their share the total population (approximately 62 percent) (see Figure 1). Furthermore, the crude death rate for blacks was 365.5 per 100,000 in 1998 (Table 6) but more than twice the white rate of 176.5 deaths per 100,000 population (Table 7). Heart disease was also the leading cause of death among the District's Hispanic residents, accounting for 20 percent of all Hispanic deaths over the period. (Table 8) Ischemic heart disease was the leading cause of death from heart disease with an average of 39 percent of all heart disease deaths in the District from 1994 through 1998. The second leading cause of death from heart disease was hypertensive heart disease.

2. Cancer

Cancer is a chronic disease, which is the second leading cause of death in both the United States and the District of Columbia. It accounts for one in every five deaths in America and in the District. One in every three Americans alive today will eventually be diagnosed with cancer. In the District of Columbia, over 3,000 new cases of cancer are reported each year. This translates into one of the nation's highest prevalence rates for cancer.

Table 6: Five Leading Causes of Death by Race: Blacks, District of Columbia, 1998		
Cause of Death	**Number of Deaths**	**Crude Rates (per 100,000 population)**
All Causes	*4,701*	*1,442.7*
1. Diseases of the Heart	1,191	365.5
2. Cancer	1, 044	320.4
3. HIV/AIDS	217	66.6
4. Homicide and Legal In…	209	64.1
5. Cerebrovascular Disease	201	61.7
All Other Causes	705	216.3
Source: DC Department of Health, State Center for Health Statistics, Washington, DC.		

Table 7: Five Leading Causes of Death by Race: Whites, District of Columbia, 1998		
Cause of Death	**Number of Deaths**	**Crude Rates (per 100,000 population)**
All Causes	*1,237*	*688.8*
1. Diseases of the Heart	317	176.5
2. Cancer	291	162.0
3. Cerebrovascular Disease	100	55.7
4. Pneumonia and Influenza	68	37.9
5. Chronic Obstructive Pulmonary Disease	56	31.2
All Other Causes	139	77.3
Source: DC Department of Health, State Center for Health Statistics, Washington, DC.		

Table 8: Five* Leading Causes of Death by Race: Hispanics, District of Columbia, 1998

Cause of Death	Number of Deaths	Crude Rates (per 100,000 population)
All Causes	*37*	*98.7*
1. Perinatal Conditions	8	21.3
2. Diseases of the Heart	6	16.0
3. Cancer	3	8.0
4. HIV/AIDS	3	8.0
All Other Causes	17	45.3

* Only four of five are in large enough numbers to be counted as significant.

Source: DC Department of Health, State Center for Health Statistics, Washington, DC.

From 1994 through 1998, 6,971 District residents died from cancer of whom 3,596 were males and 3,375 were females. During this same period, approximately 15,000 cancer cases were newly diagnosed among District residents. Cancer affects residents in every city ward.

Ward 4 residents consistently have carried the heaviest burden of cancer deaths compared to other wards. Up to the age of 79 years, a greater number of males died from cancer as compared to females. However, more females than males died of cancer after the age of 80 years, a finding that can be accounted for by the older average life expectancy of women.

Both the crude and age-adjusted death rates for cancer showed a generally declining trend. The crude death rate declined from 274.9 deaths per 100,000 population in 1994 to 229.3 deaths per 100,000 population in 1997 and increased to 258.1 per 100,000 population in 1998.

Similarly, the age-adjusted death rate for cancer declined from 183.7 deaths per 100,000 in 1994 to 147.9 deaths per 100,000 population in 1997 but increased to 158.9 in 1998.

In the District of Columbia, blacks are twice as likely to die from cancer as whites. When compared to other races (American Indians and Asian and Pacific Islanders), blacks are four times more likely to die from cancer than persons belonging to these other racial groups. The Hispanic residents of the District had a relatively low cancer death rate with 27.5 deaths per 100,000 population in 1994 and 8.0 deaths per 100,000 population in 1998 . However, cancer has been in the top three leading causes of death for Hispanics from 1994 through 1998,

accounting for 17 percent of all Hispanic deaths over this period.

3. Cerebrovascular Disease (Stroke)

Cerebrovascular disease, also known as stroke, is the second major category of cardiovascular diseases, besides heart disease, and was the third leading cause of death for 1998. Cerebrovascular disease or stroke was also the number one cause of disability. Blacks are twice as likely to suffer a stroke as whites. More women die each year from stroke than from breast cancer. However, according to the Stroke Prevention Council, 80 percent of all strokes are preventable. The crude death rate for cerebrovascular disease has been following a consistently fluctuating pattern each year since 1994. In 1994, the cerebrovascular death rate was 66.8 per 100,000 population, while in 1998, it was 57.9 per 100,000 population. The 1996 rate of 69.0 was the highest over this five-year period.

4. HIV/AIDS

Acquired immunodeficiency syndrome (AIDS) is caused by the human immunodeficiency virus (HIV). The disease is characterized by a weakened immune system, making the body susceptible to a number of infectious conditions.

In the District of Columbia, as in the nation, deaths among people with HIV/AIDS continue to decline. A decline in the death rate reflects the success of triple therapy with HIV infected patients in preventing or delaying the onset of low CD4 counts and subsequent opportunistic infections. The latest available data which compared the number of AIDS cases to the number of deaths showed that as of June 1998, there were 10,828 cumulative cases of AIDS in the District of Columbia, of which 5,795 (54 percent) were deceased. Of these, 5,724 deaths (98.8 percent) were adults/adolescents and 71 deaths (1.2 percent) were among pediatric cases (persons less than 13 years of age). However, final mortality data for 1998 showed that HIV/AIDS was the fourth leading cause of death in the District of Columbia. In 1998 there were 246 HIV/AIDS deaths of which 172 were males and 74 were females. The 1998 HIVAIDS death rate was 47.0 per 100,000 population, which is a slight increase over the 1997 rate of 46.1 per 100,000 population. Most deaths were in the 25–44 years age group (60.6 percent).

5. Pneumonia and Influenza

Pneumonia is a serious infection or inflammation of the lungs, which prevents the smooth flow of oxygen to the blood. If there is too little oxygen in the blood, the body cells cannot function properly, and as a result, infection can spread throughout the body and lead to death.

Until 1936, pneumonia was the number one cause of death in the U.S. Since then, the use of antibiotics has brought it under control. In 1997, pneumonia and influenza combined ranked as the sixth leading cause of death in the U.S. and also in the District of Columbia. However, in 1998 the death rate for pneumonia and influenza has increased to 43.8 per 100,000 popula-

tion in the District of Columbia, the highest rate for the last five years. Pneumonia and influenza constituted the fifth leading cause of death in 1998.

Residents who are 65 years and older are at the greatest risk of dying of pneumonia. In the District of Columbia, 80 percent of all pneumonia and influenza deaths in 1998 occurred in this age group.

B. Other Major Causes of Death — Infant Mortality

In 1998, there were 7,678 live births and 96 infant deaths to District residents. This resulted in an infant mortality rate (IMR) of 12.5 deaths for every 1,000 live births. This is the lowest IMR in the District's reporting history.

Over the past 10 years (1989–1998), there has been an overall declining trend in IMR as show in Figure 2 (page 4). During this ten year period, the number of infant deaths declined from 267 in 1989 to 96 in 1998, a 64 percent decline. Of the 96 infant deaths, 58.3 percent occurred during the neonatal period (under 28 days of life). The neonatal death rate was 7.3 per 1,000 live births in 1998. The postneonatal death rate (deaths occurring from 28 days to under one year of age) was 5.2 per 1,000 live births in 1998.

Vital statistics over the years have indicated that factors such as low birthweight and lack of prenatal care are positively associated with infant mortality. In 1998, the percentage of low birthweight infants (those weighing under 2,500 grams or 5.5 pounds) in the District was 13.2 compared to 13.5 percent in 1997 (Table 9). The percentage of low birthweight babies born to black mothers declined by 2.5 percent from 16.3 in 1997 to 15.9 in 1998. Comparatively, there was an 18.9 percent increase in low birthweight babies born to white mothers, from 5.3 in 1997 to 6.3 in 1998.

Table 9: Low Birthweight Babies by Race of Mother, District of Columbia, 1997–1998

Race	1997	1998	Percent Change
All Races	*13.5*	*13.2*	*-2.2*
Black	16.3	15.9	-2.5
White	5.3	6.3	18.9

Source: DC Department of Health, State Center for Health Statistics, Washington, DC.

Babies born to teenage mothers are also considered to be at relatively higher risk for infant mortality, when they are of low birthweight. In the District of Columbia, the percentage of low birthweight infants born to mothers under 20 years of age increased by 13.1 percent in 1998.

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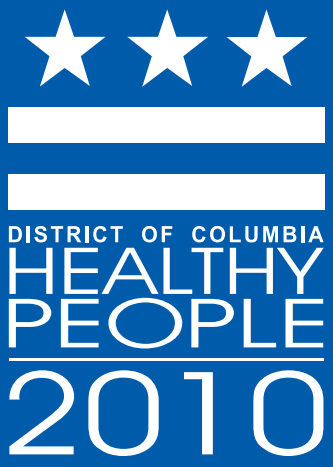

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